TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 2 PROVIDER NETWORK

8.308.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.2.1 NMAC - Rp, 8.308.2.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.2.2 SCOPE: This rule applies to the general public.
[8.308.2.2 NMAC - Rp, 8.308.2.2 NMAC, 5/1/2018]

8.308.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.308.2.3 NMAC - Rp, 8.308.2.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.2.4 DURATION: Permanent.
[8.308.2.4 NMAC - Rp, 8.308.2.4 NMAC, 5/1/2018]

8.308.2.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.2.5 NMAC - Rp, 8.308.2.5 NMAC, 5/1/2018]

8.308.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.2.6 NMAC - Rp, 8.308.2.6 NMAC, 5/1/2018]

8.308.2.7 DEFINITIONS: [**RESERVED**]

8.308.2.8 MISSION: We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net-services.
[8.308.2.8 NMAC - Rp, 8.308.2.8 NMAC, 5/1/2018; A, 7/1/2026]

8.308.2.9 GENERAL REQUIREMENTS: The HCA managed care organization (MCO) shall establish and maintain a comprehensive network of providers and required specialists in sufficient numbers to make all services included in the benefit package available in accordance with access standards. The MCO shall require any contracted provider to be enrolled through a fully executed provider participation agreement (PPA) with HCA's medical assistance division (MAD). In completing the PPA, the provider may choose to participate only in managed care, only in fee-for-service, or both. Providers who have completed a PPA can choose to pursue contracting with one or more MCOs but do not have to contract with all MCOs. The MCO shall refer any provider who notifies the MCO of a change in their location, licensure, certification, or status to the MAD provider web portal to update their provider information. In addition, the MCO shall provide an e-mail notification to MAD regarding changes in provider servicing location; change in licensure or certification; and the date on which the provider is no longer participating with the MCO, including the reason.

A. Required MCO policies and procedures:

(1) Pursuant to section 1932(b)(7) of the Social Security Act, and consistent with 42 CFR 438.12, the MCO shall not discriminate against a provider that serves high-risk populations or specializes in conditions that require costly treatment.

(2) The MCO shall not discriminate with respect to participation, reimbursement, or indemnification of any provider acting within the scope of their provider's license or certification under applicable state statute or rule solely on the basis of the provider's license or certification.

(3) The MCO shall upon declining to include an individual or a group of providers in its network, give the affected provider written notice of the reason for the MCO decision.

(4) The MCO shall conduct screenings of all subcontractors and contract providers in accordance with the Employee Abuse Registry Act, 27-7A-3 NMSA 1978, the New Mexico Caregivers Criminal

History Screening Act, 2-17-2 et seq., NMSA 1978 and 7.1.9 NMAC, the New Mexico Children's and Juvenile Facility Criminal Records Screening Act, 32A-15-1 to 32A-15-4 NMSA 1978, Patient Protection and Affordable Care Act (PPACA), and ensure that all subcontracted and contracted providers are screened against the federal "list of excluded individuals or entities" (LEIE) and the federal "excluded parties list system" (EPLS) (now known as the system for award management (SAM)) and any other databases that may be required through federal or state regulation.

(5) The MCO shall require that any provider, including a provider making a referral or ordering a covered service, have a national provider identifier (NPI) unless the provider is an atypical provider as defined by the centers for medicare and medicaid services (CMS).

(6) The MCO shall require that each provider billing for or rendering services to a MCO member has a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act.

(7) The MCO shall consider in establishing and maintaining the network of appropriate providers its:

(a) anticipated enrollment;

(b) numbers of contracted providers who are not accepting new patients; and

(c) geographic locations of contracted providers and members, considering distance, travel time, the means of transportation ordinarily used by members; and whether the location provides physical access for members with disabilities.

(8) The MCO shall ensure that a contracted provider offers hours of operation that are no less than the hours of operation offered to its commercial enrollees.

(9) The MCO shall establish mechanisms such as notices or training materials to ensure that a contracted provider comply with the timely access requirements, monitor such compliance regularly, and take corrective action if there is a failure to comply.

(10) The MCO shall provide to its members and contracted providers clear instructions on how to access covered services, including those that require prior approval and referral.

(11) The MCO shall ensure that all contracted providers meet all availability; time and distance standards set by HCA, and have a system to track and report this data.

(12) The MCO shall provide access to a non-contracted provider if the MCO is unable to provide covered benefits covered under its agreement with HCA in an adequate and timely manner to a member and continue to authorize the use of a non-contracted provider for as long as the MCO is unable to provide these services through its contracted providers. The MCO must ensure that the cost to its members utilizing a non-contracted provider is not greater than it would be if the service was provided within the MCO's network.

B. Health services contracting: Contracts with an individual and an institutional provider shall mandate compliance with the MCOs quality management (QM) and quality improvement (QI) programs.

C. Provider qualifications and credentialing: The MCO shall verify that each contracted or subcontracted provider (practitioner or facility) participating in, or employed by, the MCO meets applicable federal and state requirements for licensing, certification, accreditation and re-credentialing for the type of care or services within the scope of practice as defined by federal and state statutes, regulations, and rules.

D. Utilization of out-of-state providers: To the extent possible, the MCO is encouraged to utilize in-state and border providers, which are defined as those providers located within 100 miles of the New Mexico border, Mexico excluded. The MCO may include out-of-state providers in its network. All services must be rendered within the boundaries of the United States. No payment is allowed to any financial institution or entity located outside of the United States.

E. Provider lock-in: HCA shall allow the MCO to require that a member see a certain provider while ensuring reasonable access to quality services when identification of utilization of unnecessary services or the member's behavior is detrimental or indicates a need to provide case continuity. Prior to placing a member on a provider lock-in, the MCO shall inform the member of its intent to lock-in, including the reasons for imposing the provider lock-in and that the restriction does not apply to emergency services furnished to the member. The MCO's grievance procedure shall be made available to a member disagreeing with the provider lock-in. The member shall be removed from provider lock-in when the MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable. HCA shall be notified of provider lock-ins and provider lock-in removals at the time they occur as well as receiving existing lock-in information on a quarterly basis.

F. Pharmacy lock-in: HCA shall allow the MCO to require that its member see a certain pharmacy provider when the member's compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the MCO shall inform the member of the intent to lock-in. The MCO's grievance procedure shall

be made available to a member being designated for pharmacy lock-in. The member shall be removed from pharmacy lock-in when the MCO has determined that the compliance or drug seeking behavior has been resolved and the recurrence of the problem is judged to be improbable. HCA shall be notified of all provider lock-ins and provider lock-in removals at the time they occur as well as receiving existing lock-in information on a quarterly basis.
[8.308.2.9 NMAC - Rp, 8.308.2.9 NMAC, 5/1/2018; A, 7/1/2026]

8.308.2.10 PRIMARY CARE PROVIDER (PCP): The MCO shall ensure that each member is assigned a primary care provider (PCP), except a member that is dually eligible for medicare and medicaid (dual eligible). The PCP shall be a provider identified in Subsection A below, participating in the MCO's network who will assume the responsibility for supervising, coordinating, and providing primary health care to its member, initiating referrals for specialist care, and maintaining the continuity of the member's care. For a dual-eligible member, the MCO will be responsible for coordinating the primary, acute, behavioral health and long-term care services with the member's medicare PCP.

A. Types of PCPs: The MCO shall designate the following types of providers as a PCP as appropriate:

(1) medical doctors or doctors of osteopathic medicine with the following specialties: general practice, family practice, internal medicine, gerontology, gynecology and pediatrics;

(2) certified nurse practitioners, certified nurse midwives and physician assistants;

(3) specialists, on an individual basis, for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness, complex behavioral health conditions, or disabilities;

(4) a primary care team consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that include mid-level practitioners who, at the member's request, may serve as the point of first contact; in both instances the MCO shall organize its team to ensure continuity of care to the member and shall identify a "lead physician" within the team for each member; the "lead physician" shall be an attending physician; medical students, interns and residents may not serve as "lead physicians";

(5) federally qualified health centers (FQHC), rural health clinics (RHC), or Indian health service (IHS), tribal health providers, and urban Indian providers (I/T/U); or

(6) other providers that meet the credentialing requirements for PCPs.

B. Selection of or assignment to a PCP: The MCO shall maintain and implement written policies and procedures governing the process of member selection of a PCP and requests for change.

(1) Initial enrollment: At the time of enrollment, the MCO shall ensure that each member has the freedom to choose a PCP within a reasonable distance from their place of residence.

(2) Subsequent change in PCP initiated by a member: the MCO shall allow its member to change their PCP at any time for any reason. The request can be made in writing or verbally via telephone:

(a) if a request is made on or before the 20th calendar day of the month, the change shall be effective as the first of the following month;

(b) if a request is made after the 20th calendar day of the month, the change shall be effective the first calendar day of the second month following the request.

(3) A subsequent change in PCP initiated by the MCO: The MCO may initiate a PCP change for its member under the following circumstances:

(a) the member and the MCO agree that assignment to a difference PCP in the MCO's provider network is in the member's best interest, based on the member's medical condition;

(b) a member's PCP ceases to be a contracted provider;

(c) a member's behavior toward their PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made reasonable efforts to accommodate the member;

(d) a member has initiated legal actions against the PCP;

(e) the PCP is suspended for any reason; or

(f) A claims-based utilization analysis indicates the member's preference for a different PCP (e.g., if a member visits a particular PCP consistently, this indicates the member's choice of PCP). If indicated, the MCO may reassign the member to the best PCP option and send the member a letter indicating they've been reassigned, explaining why, and informing the member that they may always change their PCP at any time and for any reason, in writing or verbally via telephone.

(4) The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each member who

received their primary care from or was seen on a regular basis by the terminated provider. In such instances, the MCO shall allow affected members to select a PCP or the MCO shall make an assignment within 15 calendar days of the termination effective date.
[8.308.2.10 NMAC - Rp, 8.308.2.10 NMAC, 5/1/2018; A, 7/1/2026]

8.308.2.11 STANDARDS FOR ACCESS: The MCO shall establish and follow protocols to ensure the accessibility, availability and referral to health care providers for each medically necessary service to its members. The MCO shall provide access to the full array of covered services within the benefit package. If a service is unavailable based on the access guidelines, a service equal to or higher than that service shall be offered.

A. Access to urgent and emergency services: Services for emergency conditions provided by physical and behavioral health providers, including emergency transportation, urgent conditions, and post-stabilization care shall be covered by the MCO (only within the United States for both physical and behavioral health). An urgent condition exists when a member manifests acute symptoms and signs that, by reasonable medical judgment, represent a condition of sufficient severity that the absence of medical attention within 24 hours could reasonably result in an emergency condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for child and adolescent members or serious jeopardy to the behavioral health of the member are considered urgent conditions. An emergency condition exists when a member manifests acute symptoms and signs that, by reasonable lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention, including behavioral health treatment, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the member or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy. Post-stabilization care means covered services related to an emergency medical or behavioral health condition, that are provided after the member is stabilized in order to maintain the stabilized condition and may include improving or resolving the member's condition.

(1) The MCO shall ensure that there is no clinically significant delay caused by the MCO's utilization control measures. Prior authorization is not required for emergency services in or out of the MCO's network, and all emergency services shall be reimbursed at the HCA approved rate. The MCO shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical or behavioral health condition under the prudent layperson standard, turned out to be non-emergent in nature.

(2) The MCO shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency care, regardless of whether the provider is contracted with the MCO.

(3) The MCO shall ensure that the member has access to the nearest appropriately designated trauma center according to established emergency medical standards (EMS) triage and transportation protocols.

B. PCP availability: The MCO shall follow a process that ensures a sufficient number of PCPs are available to allow members a reasonable choice among providers.

(1) The MCO shall have at least one PCP available per 2,000 members and not more than 2,000 members are assigned to a single provider unless approved by HCA.

(2) The MCO must ensure that members have adequate access to specialty providers.

(3) The minimum number of PCPs from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier. Urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana. Frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola. Rural counties are those that are not urban or frontier. The standards are as follows:

(a) ninety percent of urban member residents shall travel no farther than 30 miles;

(b) ninety percent of rural member residents shall travel no farther than 45 miles; and

(c) ninety percent of frontier member residents shall travel no farther than 60 miles.

C. Pharmacy provider availability: The MCO shall ensure that a sufficient number of pharmacy providers are available to its members. The MCO shall ensure that pharmacy services meet geographic access standards based on its member's county of residence. The access standards are as follows:

(1) ninety percent of urban residents shall travel no farther than 30 miles;

(2) ninety percent of rural residents shall travel no farther than 45 miles; and

(3) ninety percent of frontier residents shall travel no farther than 60 miles.

D. For all other provider types, including, but not limited to behavioral health providers, physical health providers, long term care providers, hospitals and transportation providers, as directed by MAD, the following standards shall apply:

(1) ninety percent of urban residents shall travel no farther than 30 miles;

(2) ninety percent of rural residents shall travel no farther than 60 miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted by MAD; and

(3) ninety percent of frontier residents shall travel no farther than 90 miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted by MAD.

E. The MCO must provide transportation as necessary to meet the standards of access.

[8.308.2.11 NMAC - Rp, 8.308.2.11 NMAC, 5/1/2018; A, 7/1/2026]

8.308.2.12 ACCESS TO HEALTH CARE SERVICES: The MCO shall ensure that there are a sufficient number of PCPs and dentists available to members to allow members a reasonable choice, and ensure that there are a sufficient number of behavioral health providers, based on the least restrictive, medically necessary needs of its members, available statewide to members to allow members a reasonable choice.

A. The MCO shall report to HCA all provider groups, health centers and individual physician practices and sites in its network that are not accepting new MCO members.

B. For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than 30 calendar days, unless the member requests a later time.

C. For routine asymptomatic member-initiated dental appointments the request-to-appointment time shall be no more than 60 calendar days unless the member requests a later date.

D. For routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

E. For non-urgent behavioral health care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

F. Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours.

G. For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in Subsection E of this Section, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 calendar days, unless the member requests a later time.

H. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 calendar days, unless the member requests a later time.

I. For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need.

J. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours.

K. The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

L. The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes.

M. The MCO's preferred drug list (PDL) shall follow HCA guidelines for services and items included in the managed care benefit package, pharmacy services.

N. Access to durable medical equipment: The MCO shall approve or deny a request for new durable medical equipment (DME) or for repairs to existing DME owned or rented by the member within seven working days of the request date.

(1) All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 calendar days of the request date.

(2) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(3) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(4) All DME repairs or non-customized modifications shall be delivered within 60 calendar days of the request date.

(5) The MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.

(6) The MCO shall ensure that its member and their family or caretaker receive proper instruction on the use of DME provided by the MCO or its subcontractor.

O. Access to prescribed medical supplies: The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The MCO shall ensure that:

(1) a member can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(2) a member can access routine medical supplies within a time frame consistent with the clinical need;

(3) subject to any requirements to procure a PCP order to provide supplies to its members, members utilizing medical supplies on an ongoing basis shall submit to the MCO lists of needed supplies monthly; and the MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need; and

(4) the MCO shall ensure that its member and their family receive proper instruction on the use of medical supplies provided by the MCO or its subcontractors.

P. Access to transportation services: The MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The MCO shall have sufficient transportation providers available to meet the needs of its members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependent or have other equipment needs. The MCO shall develop and implement policies and procedures to ensure that:

(1) transportation arranged is appropriate for the member's clinical condition;

(2) the history of services is available at the time services are requested to expedite appropriate arrangements;

(3) CPR-certified drivers are available to transport members consistent with clinical need;

(4) the transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers;

(5) members can access and receive authorization for medically necessary transportation services under certain unusual circumstances without advance notification; and

(6) minor aged members are accompanied by a parent or legal guardian as indicated to provide safe transportation. See 8.301.6 NMAC for a detailed description of attendant coverage for a member 18 years of age and older.

Q. Use of technology: The MCO is encouraged to use technology, such as telemedicine, to ensure access and availability of services statewide.

R. For behavioral health crisis services, face-to-face appointments shall be available within two hours.

[8.308.2.12 NMAC - Rp, 8.308.2.12 NMAC, 5/1/2018; A, 7/1/2026]

8.308.2.13 SPECIALTY PROVIDERS: The MCO shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of the members are met within the MCO's provider network. The MCO shall also have a system to refer members to non-contracted providers if providers with the necessary qualifications or certifications do not participate in the network. Out-of-network providers must coordinate with the MCO with respect to payment. The MCO must ensure that cost to its member is no greater than it would be if the services were furnished within the network.

[8.308.2.13 NMAC - Rp, 8.308.2.13 NMAC, 5/1/2018]

8.308.2.14 FAMILY PLANNING PROVIDERS:

A. The MCO shall give each adolescent and adult member the opportunity to use their own PCP or to use any family planning provider for family planning services without requiring a referral. Each female member shall also have the right to self-refer to a contracted women's health specialist for covered services necessary to provide women's routine and preventive health services. This right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist. Family planning providers, including those funded by Title X of the public health service, shall be reimbursed by the MCO for all covered family planning services, regardless of whether they are contracted providers of the member's MCO. Unless otherwise negotiated, the MCO shall reimburse providers of family planning services pursuant to the medicaid fee schedule.

B. Pursuant to state statute and rule, a non-contracted provider is responsible for keeping family planning information confidential in favor of the individual member even if the member is a minor. The MCO is not responsible for the confidentiality of medical records maintained by a non-contracted provider, but shall notify the non-contracted provider of the confidentiality provisions contained herein.
[8.308.2.14 NMAC - Rp, 8.308.2.14 NMAC, 5/1/2018; A, 7/1/2026]

8.308.2.15 INDIAN HEALTH SERVICES, TRIBAL HEALTHCARE, AND URBAN INDIAN PROVIDERS (I/T/U):

A. The MCO shall make best efforts to contract with I/T/Us in the state, including, but not limited to, contracting for such services as transportation, care coordination and case management. The MCO is encouraged to use the sample I/T/U addendum as described in 42 CFR 438.14 to develop an addendum specific to New Mexico that can be used to establish network provider agreements with I/T/Us as such agreements include the federal protections for I/T/Us.

B. The MCO shall allow native American members to seek care from any I/T/U whether or not the I/T/U is a contract provider and shall reimburse I/T/Us as specified in 8.308.20 NMAC. The MCO shall permit non-contracted I/T/Us to refer native American members to a contracted provider.

C. The MCO shall not prevent members from seeking care from I/T/Us or from contract providers due to their status as native Americans.
[8.308.2.15 NMAC - N, 5/1/2018]

8.308.2.16 STANDARDS FOR CREDENTIALING AND RE-CREDENTIALING: The MCO shall verify that each contracted or subcontracted provider participating in, or employed by the MCO meets applicable federal and state requirements for licensing, certification, accreditation and re-credentialing for the type of care or services within the scope of practice as defined by federal medicaid statues and state law. The MCO shall verify that billing providers, rendering providers, ordering providers, attending providers, and prescribing providers are enrolled with MAD, unless the services or providers are otherwise exempted by MAD. The MCO shall document the mechanism for credentialing and re-credentialing of a provider with whom it contracts or employs to treat its members outside the inpatient setting and who fall under its scope of authority. The documentation shall include, but not be limited to, defining the provider's scope of practice, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions, and the extent of delegated credentialing or re-credentialing arrangements. The credentialing process shall be completed within 45 calendar days from receipt of completed application with all required documentation unless there are extenuating circumstances. The MCO shall use the HCA approved primary source verification entity or one entity for the collection and storage of provider credentialing application information unless there are more cost effective alternatives approved by HCA. The MCO must load provider contracts and claims systems must be able to recognize the provider as a network provider no later than 45 calendar days after a provider is credentialed, when required.

A. Practitioner participation: The MCO shall have a process for receiving input from participating providers regarding credentialing and re-credentialing of its providers.

B. Primary source verification: The MCO shall verify the following information from primary sources during its credentialing process:

(1) a current valid license to practice;

(2) the status of clinical privileges at the institution designated by the practitioner as the primary admitting facility, if applicable;

(3) valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate, if applicable;

(4) education and training of practitioner including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the practitioner;

(5) board certification if the practitioner states on the application that they are board certified in a specialty;

(6) current, adequate malpractice insurance, according to the MCOs policy and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(7) primary source verification shall not be required for work history.

C. Credentialing application: The MCO shall use the HCA approved credentialing form. The provider shall complete a credentialing application that includes a statement by them regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity;

(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and

(6) applicant attests to the correctness and completeness of the application.

D. External source verification: Before a practitioner is credentialed, the MCO shall receive information on the practitioner from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the practitioner type;

(2) information about sanctions or limitations on licensure from the following agencies, as applicable:

(a) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(b) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(c) state board of dental examiners;

(d) state board of podiatric examiners;

(e) state board of nursing;

(f) the appropriate state licensing board for other practitioner types, including behavioral health; and

(g) other recognized monitoring organizations appropriate to the practitioner's discipline;

(3) a health and human services (HHS) office of inspector general (OIG) exclusion from participation on medicare, medicaid, the children's health insurance plan (CHIP), and all federal health care programs (as defined in Section 1128B(f) of the Social Security Act), and sanctions by medicare, medicaid, CHIP or any federal health care program.

E. Evaluation of practitioner site and medical records: The MCO shall perform an initial visit to the offices of a potential PCP, obstetrician, and gynecologist, and shall perform an initial visit to the offices of a potential high volume behavioral health care practitioner prior to acceptance and inclusion as a contracted provider. The MCO shall determine its method for identifying high volume behavioral health practitioners.

(1) The MCO shall document a structured review to evaluate the site against the MCO's organizational standards and those specified by the HCA managed care contract.

(2) The MCO shall document an evaluation of the medical record keeping practices at each site for conformity with the MCO's organizational standards.

F. Re-credentialing: The MCO shall have formalized re-credentialing procedures.

(1) The MCO shall re-credential its providers at least every three years. The MCO shall verify the following information from primary sources during re-credentialing:

(a) a current valid license to practice;

(b) the status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;

(c) valid DEA or CSR certificate, if applicable;

(d) board certification, if the practitioner was due to be recertified or became board certified since last credentialed or re-credentialed;

(e) history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(f) a current signed attestation statement by the applicant regarding:

(i) ability to perform the essential functions of the position, with or without accommodation;

(ii) lack of current illegal drug use;

(iii) history of loss or limitation of privileges or disciplinary action; and

(iv) current professional malpractice insurance coverage.

(2) There shall be evidence that, before making a re-credentialing decision, the MCO has received information about sanctions or limitations on licensure from the following agencies, if applicable:

(a) the national practitioner data bank;

(b) medicare and medicaid;

(c) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(d) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(e) state board of dental examiners;

(f) state board of podiatric examiners;

(g) state board of nursing;

(h) the appropriate state licensing board for other provider types;

(i) other recognized monitoring organizations appropriate to the provider's discipline; and

(j) HHS/OIG exclusion from participation in medicare, medicaid, CHIP and all federal health care programs.

(3) The MCO shall incorporate data from the following sources in its re-credentialing decision making process for its providers:

(a) member grievances and appeals;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted under Subsection E this Section.

G. Imposition of remedies: The MCO shall have policies and procedures for altering the conditions of the provider's participation with the MCO based on issues of quality of care and service. These policies and procedures shall define the range of actions that the MCO may take to improve the provider's performance prior to termination:

(1) The MCO shall have procedures for reporting to appropriate authorities, including HCA, serious quality deficiencies that could result in a practitioner's suspension or termination.

(2) The MCO shall have an appeal process by which the MCO may change the conditions of a practitioner's participation based on issues of quality of care and service. The MCO shall inform providers of the appeal process in writing.

H. Assessment of organizational providers: The MCO shall have written policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted. At least every three years, the MCO shall:

(1) confirm that the provider has been certified by the appropriate state certification agency, when applicable; behavioral health organizational providers and services are certified by the following;

(a) the department of health (DOH) is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and

(b) the children, youth and families department (CYFD) is the certification agency for child and adolescent behavioral health organizational services and providers that require certification; and

(2) confirm that the provider has been accredited by the appropriate accrediting body or has a detailed written plan expected to lead to accreditation within a reasonable period of time; behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredited by the joint commission (JC); other child behavioral health organizational services or providers are accredited by the council on accreditation (COA); and

(c) organizational services or providers who serve adults, children and adolescents are accredited by either CARF or COA.

[8.308.2.16 NMAC - Rp, 8.308.2.15 NMAC, 5/1/2018; A, 7/1/2026]

8.308.2.17 PROVIDER TRANSITION: The MCO shall notify HCA within five calendar days of unexpected changes to the composition of its provider network that would have an effect on member access to services or on the MCOs ability to deliver services included in the benefit package. Anticipated material changes in the MCO provider network shall be reported in writing to HCA within 30 calendar days prior to the change or as soon as the MCO becomes aware of the anticipated change. For both expected and unexpected changes in the network, the MCO shall be required to assess the significance of the change or closure to the network and shall submit a notification narrative and specific transition plans, if applicable, as detailed in the MCO policy manual.

[8.308.2.17 NMAC - Rp, 8.308.2.16 NMAC, 5/1/2018; A, 7/1/2026]

8.308.2.18 DELEGATION: Delegation is a process whereby a MCO gives another entity the authority and responsibilities to perform certain functions on its behalf. The MCO is fully accountable for all pre-delegation and delegation activities and decisions made. The MCO shall document its oversight of the entity that performs the delegated activity. The MCO may assign, transfer, or delegate to a subcontractor key management functions with the explicit written approval of HCA.

A. Each contract or written agreement between the MCO and delegated entity shall describe:

(1) the responsibilities of the MCO and the entity to which the activity is delegated;

(2) the delegated activities or obligations;

(3) the reporting responsibilities to include the frequency and method of reporting to the MCO;

(4) the process by which the MCO evaluates the delegated entity's performance;

(5) the remedies up to, and including, revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations; and

(6) the requirements specified in 42 CFR § 438.214, if the delegated entity will be providing or securing covered services to members.

B. The MCO shall provide evidence to HCA that it:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) monitors the delegated entity's performance on an ongoing basis and identifies deficiencies or areas for improvement that require the delegated entity to take corrective action as necessary; and

(3) conducts an annual evaluation of its delegated entity in accordance with the MCO's expectations and HCA's standards.

[8.308.2.18 NMAC - Rp, 8.308.2.17 NMAC, 5/1/2018; A, 7/1/2026]

HISTORY OF 8.308.2 NMAC: [RESERVED]

History of Repealed Material:

8.308.2 NMAC - Managed Care Program, Provider Network, filed 12/17/2013 Repealed effective 5/1/2018.